PERSONAL INJURY QUESTIONNAIRE

Name_____Phone ( )_____
Address_____City_____State_____Zip_____
Age _____ Birthdate _____ Sex_____ SS#_____
Employer's Name _____
Employer's Address _____
Insurance Co._____Phone#_____
Agent _____Claim# _____
Responsible Party's Name _____
Address_____City_____State_____Zip_____
ATTORNEY
Name_____Phone ( )_____
Address_____City_____State_____Zip_____
Were there any witnesses? ( ) Yes ( ) No Name(s) _____

NATURE OF ACCIDENT:

1. Date of Accident _____ Time of Day _____
2. Were you: ( ) Driver ( ) Passenger ( ) Front Seat ( ) Back Seat
3. Number of people in your vehicle? _____ Were you wearing seat belts? _____
4. What direction were you headed? ( ) North ( ) East ( ) South ( ) West
   On (name of street) _____
5. What direction was the other vehicle headed? ( ) North ( ) East ( ) South ( ) West
   On (name of street) _____
6. Were you struck from: ( ) Behind ( ) Front ( ) Left side ( ) Right side
7. Approximate speed of your car _____mph Other car _____mph
8. Were you knocked unconscious? ( ) Yes ( ) No If yes, for how long? _____
9. Were police notified? ( ) Yes ( ) No
10. In your own words, please describe accident:

    _____
    _____
    _____

11. Did you have any physical complaints BEFORE THE ACCIDENT? ( ) Yes ( ) No
    If yes, please describe in detail:

    _____
    _____
    _____

12. Please describe how you felt:
    a. DURING the accident :_____
    b. IMMEDIATELY AFTER the accident:_____
    c. LATER THAT DAY:_____
    d. THE NEXT DAY:_____

13. What are your PRESENT complaints and symptoms?

    _____

    _____

14. Do you have any congenital (from birth) factors which relate to this problem? ( ) Yes ( ) No
    If yes, please describe:

    _____

15. Do you have any previous illnesses which relate to this case? ( ) Yes ( ) No
    If yes, please describe:

    _____

16. Have you ever been involved in an accident before? ( ) Yes ( ) No
    If yes, please describe, including date (s) and type(s) of accidents as well as injury(ies) received.

    _____

    _____

17. Where were you taken after the accident?_____
18. Have you been treated by another doctor since the accident? ( ) Yes ( ) No
    If yes, please list the Doctor's name and address:_____

    _____

19. Since this injury occurred, are your symptoms: ( ) Improving ( ) Getting worse ( ) Same
20. CHECK SYMPTOMS YOU HAVE NOTICED SINCE THE ACCIDENT:

__ Headache	__Irritability	__Numbness in toes	__Face Flushed	__Feet Cold
__Neck pain	__Chest pain	__Shortness of breath	__Buzzing in ears	__Hands cold
__ Neck stiff	__Dizziness	__Fatigue	__ Loss of balance	__Stomach upset
__Sleeping problems	__Head seems heavy	__Depression	__ Fainting	__ Constipation
__Back pain	__Pins & Needles- (arms)	__Lights bother eyes	__Loss of smell	__Cold sweats
__Nervousness	__ Pins & Needles- (legs)	__Loss of Memory	__Loss of taste	__Fever
__Tension	__Numbness in fingers	__ Ears ring	__Diarrhea	__Other

    Symptoms other than above:_____

21. Have you lost time from work as a result of the accident? ( ) Yes ( ) No If yes, please complete this question.
    a. Last day worked:_____
    b. Type of employment:_____
    c. Are you being compensated for time lost from work? ( ) Yes ( ) No If yes, please state type of compensation you are receiving:_____
22. Do you notice any activity restrictions as a result of this injury? ( ) Yes ( ) No If yes, please describe in detail: _____

    _____

    _____

23. Other pertinent information:

    _____

    _____

_____ _____

Date Patient's Signature